maryland
health services
cost review commission

MEMORANDUM

TO: Martha G. Rymer, Commissioner/Reviewer, MHCC
Kevin McDonald, Chief, Certificate of Need Division, MHCC

FROM: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Director, Revenue & Regulation Compliance, HSCRC

DATE: August 14, 2020

RE: Suburban Hospital, Inc. ("Suburban")
Application to Establish Liver Transplant Services
Docket No. 17-15-2400

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This memo is in response to your request dated November 15, 2019. Suburban has submitted an application for a Certificate of Need ("CON") to establish liver transplant services. You have requested that the staff of the HSCRC provide its opinion on the general financial feasibility and viability of the proposed liver transplant services and provide insight regarding certain assumptions made. MedStar Georgetown University Hospital ("Georgetown") is recognized as an interested party in this review.

EXISTING PROGRAMS:
Maryland currently has two liver transplant programs, both in Baltimore. One is at The Johns Hopkins Hospital ("JHH") and the other is at University of Maryland Medical Center ("UMMC"). Georgetown has a liver transplant program in the District of Columbia.

THE PROJECT:
Suburban is part of Johns Hopkins Medicine, and the proposed liver transplant program would be staffed by the Johns Hopkins Comprehensive Transplant Center. There are no capital costs associated with the development of this program. Suburban projects that if its program is approved, the existing programs will see a reduction of 10 or fewer cases per year through the first five years of operation. Specifically Suburban projects that, by the fifth year of operation, JHH would lose 5.1%, UMMC 4.6%, and Georgetown 6.9% of existing cases to Suburban. Suburban also projects that an additional 10 liver transplant cases will take place each year as a result of its new program.

Financially Suburban anticipates that the transplant program will have a net loss of $1,187,921 in year one because the first ten transplant cases performed at the hospital will not be reimbursed,. It projects a net income of $979,382 in year two, followed by increasing levels of net income in subsequent years.

BACKGROUND:
The chapter of the State Health Plan that addresses organ transplant services, COMAR 10.24.15, ("Organ Transplant Chapter"), requires an applicant to address whether its proposed program is cost effective as compared to existing programs in its proposed service area. Suburban states that its charges for liver transplantations will be lower than those of JHH. It arrives at this conclusion by identifying applicable HSCRC Rate Centers for qualifying liver transplantation cases performed at JHH, then substituting Suburban's rates. Suburban calculated that its liver transplantation charges ($148,208) would be about 17% lower than charges at JHH ($172,955). Suburban derives these total charges for liver transplant patients by using FY16 Suburban allowable unit rates and JHH liver

transplant patients' utilization of pre-transplant, transplant, post-transplant, and outpatient care. Suburban states that it was unable to quantify charges at the other two existing centers because transplant center charges can vary significantly depending upon donor type, differing levels of acuity, and whether or not a transplant is liver-only or multi-organ. Suburban surmises that the charge experience at JHH is likely more reflective of the charge experience at Georgetown, UMMC, and other academic medical centers than it would be at Suburban, a community hospital.

QUESTIONS from MHCC to HSCRC:

1) Does Suburban present plausible revenue and expense assumptions that reflect appropriate shifts related to new payment models, and account for recent expansions and modernizations at the hospital?

2) Would a new liver transplantation program at Suburban be expected to have lower charges and therefore be more cost effective than the programs at JHH, UMMC, and Georgetown? Can the HSCRC quantify difference in charges for liver transplant services among these providers?

3) How will a shift in liver transplant cases from Georgetown to Suburban, and the resultant Medicare dollar shift for these cases from the District of Columbia to Maryland, impact the spending and savings targets HSCRC must meet under the Medicare Waiver?

HSCRC REVIEW, DISCUSSION, and OPINION:

HSCRC staff has reviewed the CON application dated June 28, 2017 and the subsequent Suburban Completeness Responses dated November 3, 2017, and February 18, 2018, and Suburban Interested Party Responses dated May 15, 2018.

Upon review of the statistical and financial information provided in the CON and subsequent completeness responses, it was noted that such information was most recently updated as submitted November 3, 2017, reflecting actual data through fiscal 2016 and projected data beginning with fiscal 2017. The five (5) years of operations for the transplant services were projected to be fiscal 2019 through fiscal 2023. Given that at this time, fiscal 2020 has come to pass, and it is very likely that the operation if approved, would not begin in earnest before fiscal 2022 or perhaps fiscal 2023, staff is acknowledging that the projections are likely at least three (3) years old, and perhaps four (4). We have received notice from the MHCC that we are not to expect responses to our inquiries previously submitted to them, and we are not to expect to receive updated projections. Therefore, we have based our opinion upon what we have reviewed. Accordingly, our opinion is conditioned upon any material changes to the information reviewed had updated data been made available.

1) Consistent with the assumptions presented in the CON, all of Maryland's facilities (inclusive of Suburban) would continue to achieve liver transplant volumes in excess of the minimums required, even after Suburban's liver transplant service matured and volumes grew. The minimum annual case volume for liver transplant programs is twelve (12) cases per year.

After netting out the revenue projected for the liver transplant services, the projected gross patient service revenues for the entire facility, with inflation, as presented on Table H appear reasonable through fiscal year 2021 compared to the approved Global Budgeted Revenue (GBR) for Suburban. The average annual growth rate projected on such revenue beyond fiscal 2021 is 3.5%, which is reasonable compared to Suburban's average annual GBR growth rate of approximately 4%.

The average annual operating profit margin for the entire facility, as per the audited financial statements, for the five (5) years ended fiscal 2019 was 4.5%. The average annual operating profit margin for the entire facility with inflation as presented on Table H for the five (5) years ending fiscal 2023 is projected to be 2.9%. If the five (5) years ending fiscal 2023 were presented without the profits assumed on the liver transplant services, such average operating margin would measure approximately 2.5%. Holding all else equal this would imply a conservative projection of operating expenses and resulting margins, save for any impact of the current pandemic.

Based upon staff's review of the information presented and conditioned upon any material changes to that information that may have been brought to light, the HSCRC believes that the Liver Transplant services project may be financially feasible. However, staff has not received a response to the questions that were forwarded to the MHCC, nor has the staff been afforded an opportunity to discuss how Suburban calculated the additional revenue assumed in Table K. While staff realizes that Suburban would receive some increase to its GBR revenue if the program is approved, staff is not sure whether the revenue assumed in the projections are reasonable or not.

2) Generally, the organ acquisition and direct transplant costs should be relatively uniform across the hospitals. If all the programs are operating with approximately the same number of physicians, cost of supplies, length of stay, and other direct costs, etc. then the main difference would be overhead cost, indirect cost and capital costs at Suburban versus JHH or UMMC. The indirect costs will be lower at a community hospital when compared to an academic medical center. Staff can't comment on Georgetown since we don't regulate them nor have the data available to do so.

In general, academic medical centers have higher overhead and indirect costs than community hospitals. They are included in a separate peer group to help account for these differences. Holding all else equal the overhead, indirect, and capital costs at Suburban will be less than that of JHH and UMMC, and likely result in a lower overall rate structure that reflects the lower cost of a nonacademic medical center. Additionally, Suburban is a relatively efficient provider as measured in the Inter-hospital Cost Comparison (ICC) compared to other community hospitals. Again, if the direct costs are comparable, then the overhead and indirect costs would be more in line with a community hospital and most likely result in a lower set of unit rates than an academic medical center.

3) In general, this proposal to add liver transplants to Suburban lines up with staff's belief that border or regional/national hospitals have a built in advantage in our model in that they can lower their cost per case while at the same time not negatively affect total cost of care performance, because these hospitals can export a service to a non-Maryland resident, thereby spreading fixed costs over more patients that have no bearing on Maryland resident Total Cost Of Care (TCOC.)

In terms of the impact on the Maryland Medicare Waiver, Suburban would be subject to a market shift adjustment for Maryland residents currently being provided these services at another Maryland hospital. If the charges at Suburban are less than the other academic medical centers, as Suburban has estimated, then the impact would be positive.

For volumes currently being provided outside of Maryland there exists a methodology that was previously used for JHH that staff believes could be employed for Suburban as well. Staff suggests that Suburban may be allowed a charge per case that would consider the full cost of the organ plus a 50% variable cost factor applied to all other charges. If this is the final methodology used, the impact would depend on how much the patient is currently being charged at Georgetown compared to the new GBR allowed revenue.